## Adult Health Screening Questionnaire

Please customize this form to suit your research requirements.

The form will be read by a machine. Therefore it is important to use blue or black ballpoint pen and write clearly.

**Recipient's name**

**Date of Birth**

D D / M M / Y Y Y Y

**Age**

**Ethnicity** *(Please cross one)*

◯ White ◯ Mixed ◯ Asian ◯ Black

**Blood Type** *(Please cross one)*

◯ A ◯ B ◯ AB ◯ O

**Patient's Temperature** . °C

**Have you travelled outside of the Country in the last 14 days?** *(Please cross one)*

◯ Yes ◯ No

**Have you had contact with anyone who has travelled to an area with a known outbreak in the last 14 days?** *(Please cross one)*

◯ Yes ◯ No

**Do you have any allergies?** *(Please cross one)*

◯ Yes ◯ No

**During the past 12 months have you had swine influenza or other influenza-like illness?** *(Please cross one)*

◯ Yes ◯ No

**If you had influenza, mark which symptoms you had and how many days they lasted.**

*Please cross all that apply*

| | No | Yes | 0-2 days | 3-5 days | More than 5 |
|---|---|---|---|---|---|
| 1. Headache | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Stuffy nose / runny nose | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Sore throat | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. Cough | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Shortness of breath | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Chest pain | ☐ | ☐ | ☐ | ☐ | ☐ |

*To respond ⊗ or ●*

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*Please cross all that apply*

| | *No* | *Yes* | *0-2 days* | *3-5 days* | *More than 5* |
|---|---|---|---|---|---|
| 7. Fever below 39.0 | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Fever of 39.0 or higher | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9. Fever (not measured) | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. Convulsions | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11. Other convulsions | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12. Joint pain | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13. Muscle pain | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14. Vomiting, diarrhoea | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15. Ear infection | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16. Pneumonia | ☐ | ☐ | ☐ | ☐ | ☐ |

**Do you have one or more of the following diseases / conditions?**

*Please cross one in each line*

| | *1. Asthma* | *2. Diabetes type 1* | *3. Diabetes type 2* | *4. Other lung disease* | *5. Severe overweight* | *6. Cardiovascular disease* | *7. Kidney disease* | *8. Impaired immune system* |
|---|---|---|---|---|---|---|---|---|
| Yes | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| No | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

**Have you had a flu vaccination within the last nine months?** *(Please cross one)*

◯ Yes ◯ No

**If you have visited a foreign country in the past three months, please indicate here**

**Please describe how you are feeling today**

Office-use only. Please leave the following fields empty.

*To respond* ⊗ *or* ●

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**Recent illness or infection** *(Please cross one)*

◯ Positive ◯ Negative



*To respond ⊗ or ●*

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